University of Nebraska Lincoln

UNIVERSITY HEALTH CENTER

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION - DENTAL

Patient Name _____ Date of Birth _____

*Please Print*

Address _____ City/State/Zip _____

Phone (_____)_____ UNL ID / Other ID Number _____

I authorize ***Provider/Facility Name*** _____ Phone (_____)_____

Address _____ City/State/Zip _____

To release my medical information to: **University Health Center** **Phone: 402-472-7495**
**Attn: Dental Office** **Fax: 402-472-8010**
**1500 U Street**
**Lincoln, NE 68588-0618**

I authorize the **University Health Center** to release my dental information **to:**

Name (*Person/Organization*)_____ Phone (_____)_____

Address _____ City/State/Zip _____

| **Information to be requested/released:** | **Date(s) of Service:** |
|---|---|
| ___ Dental Treatment Records<br>___ Dental X-rays<br>___ Referral Letter | **From** _____ **To** _____ |

**Purpose**

___ Dental Care ___ Self
___ Insurance ___ Legal/Attorney
Other: _____

**Include information relating to:**

Yes ___ HIV testing/infection or AIDS
Yes ___ Psychiatric care/mental health
Yes ___ Treatment for alcohol and/or drug abuse

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 180 days after the date of execution by the patient or their representative.

I may request a copy of this authorization. If I do not sign this form, the University Health Center will not release my information to any person or organization except those authorized by law. My health care or payment for care will not be affected by my refusal to sign. Once disclosed, Federal privacy regulations will no longer apply and the information may be subject to redisclosure. A photocopy of this authorization is as valid as the original.

**Patient Signature** _____ **Date** _____

**Representative/Parent Signature** _____

**Relationship** _____ **Date** _____